NAS Use of Restrictive Practice in NAS Schools and Services (Policy and Procedure) – SO-0039

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TABLE OF CONTENTS

1. Scope 2
2. Purpose 2
3. Introduction 2
4. Legal context 3
5. Restrictive Physical Interventions 5
6. Seclusion 7
7. Principles for the use of restrictive practices 11
8. Debriefing (RRN Key Strategy 6) 13
9. Training (RRN Key Strategy 1-5) 13
10. Recording, reporting and monitoring (RRN Key Strategy 6) 17
11. Responsibilities 17
12. Complaints 18
13. Whistleblowing 18

Related Documents 20

1. Scope

This policy applies to all National Autistic Society services that provide support for children, young people and adults where the National Autistic Society has a duty of care.

2. Purpose

The purpose of this policy document is:

1. To state the National Autistic Society's philosophy towards restrictive practice(s) within the relevant legal and regulatory framework.
2. To give guidance to staff in order to enable them to be clear as to what forms of restrictive practices are permissible and when they should be considered.
3. To give clear guidance to staff about which forms of restrictive practices are never acceptable and the reasons for this.
4. To ensure that the use of restrictive practices are minimized, and clear reduction plan(s) and strategies exist for those where restrictive practice is necessary.

The rights and dignity of people who use National Autistic Society services, even when behaving in a physically challenging way, must always be borne in mind. Any restrictive practice must be used with a view to keeping them and others safe, with the aim of allowing the individual not only to recover self-control, but also to acquire alternative adaptive behaviours that, over time, decrease the level of intervention needed.

NOTE - Procedure for admission to a school or service where an individual is dependent on seclusion or restraint to manage his or her behaviour must be read in conjunction with this Policy (Related Document - SO-0039-005-0617).

3. Introduction

Autistic individuals sometimes behave in ways that others can find challenging and which, on some occasions, may be dangerous; potentially resulting in harm to the person displaying the behaviour, peers, staff or the public. Such behaviours may initially appear to be unpredictable and can be frightening for all concerned including the person displaying the behaviour.

Across the United Kingdom, the primary duty of the National Autistic Society as a care and education provider is to ensure the people we support are safe from harm. The fundamental but complex need to balance the right to freedom, dignity and respect, with ensuring safety from harm is at the heart of this policy and guidance (The Restraint Reduction Network (RRN) Key Strategy 1).

There are a variety of approaches and strategies that can be used to prevent situations from developing into incidents likely to cause harm such as: de-escalation, low arousal techniques

and other examples of Positive Behaviour Support – refer to Behaviour Support in Schools & Adult Services policy (SO-0029).

However, on some occasions it may be necessary to use, as a last resort, a strategy that includes a restrictive practice. Any form of restrictive practice will only be used in order to maintain the welfare and safety of the people we support and others. Staff will be trained in approved techniques and any unplanned interventions outside of an individual's positive behaviour support plan will be investigated to ensure that action taken was proportionate and applicable at the time to prevent harm to the individual or others.

4. Legal context

British Institute of Learning Disabilities define a restrictive practice as:

'The implementation of any practice or practices that restrict an individual's movement, liberty and freedom to act independently without coercion or consequence. Restrictive practices are highly coercive actions that are deliberately enacted to prevent a person from pursuing a particular course of action" - BILD Code of practice 4th edition.

Regarding physical intervention, the crux of common law (both criminal and civil) is that;

- Any threat of non-consensual touching is an **assault**,
- Any actual touching is **battery**
- Any wrongful hindrance to mobility is **false imprisonment.**

The law recognises that there are situations where some restrictive practice is necessary as an act of care. For example, if someone has a learning disability, mental illness or related disorder, that puts someone at risk, carers may have a legal duty to restrain the person in his or her own interests. Where someone takes on a caring role, he or she owes a 'duty of care' to the person. This means that the carer must do what is reasonable to protect the person from reasonably foreseeable harm. If someone's actions could put other people at risk, staff have a duty of care to respond positively, which might include as a last resort restraining the person to prevent harm.

To ensure that we follow best practice when managing signs of stress and physically challenging behaviour, we follow and adhere to the guidance within the BILD codes of Practice and the RRN guidance, the guidelines include trainer and trainee codes of practice and the 6 key strategies to the reduction of the use of restraint.

The 6 Key strategies for restraint reduction are;

1. **Strategy One: Leadership.** The organisation develops a mission, philosophy and guiding values which promote non-coercion and the avoidance of restraint. Executive leaders commit to developing a restraint reduction plan which is implemented and measured for continuous improvement.
2. **Strategy Two: Performance Measurement.** The organisation takes a 'systems' approach and identifies performance measures which determine the effectiveness of its restraint reduction plan and which measure key outcomes for customers.
3. **Strategy Three: Learning and Development.** The organisation develops its staff with the knowledge and skills to understand and prevent crisis behaviour. Training is provided which gives staff the key competencies and supports the view that restraint

is used as a last resort to manage risk behaviour associated with aggression, violence and acute behavioural disturbance.

4. **Strategy Four: Providing Personalised Support.** The organisation uses restraint reduction tools which inform staff and shape personalised care and support to customers.
5. **Strategy Five: Communication and Customer Focus.** The organisation fully involves customers in a variety of roles within the service, identifies the needs of customers and uses these to inform service provision and development.
6. **Strategy Six: Continuous Improvement.** The principle of post-incident support and learning is embedded into organisational culture.

For the National Autistic Societies Services in **Scotland Only** - refer to best practice from the Mental Welfare Commission for Scotland, Rights and Limits to Freedom and Holding Safely: A Guide for Residential Child Care Practitioners and Managers about Physically Restraining Children and Young People.

Anyone using restraint must make sure they comply with the law. Inappropriate or excessive restraint is a violation of human rights and could be an assault and result in criminal proceedings.

There is no specific piece of legislation dealing with 'restraint', setting out what is lawful in a care setting and what is not.

The law relating to the use of restraint is largely the common law. This is law which has developed over the years as cases come before the courts. Certain powers to restrain may be available under the Adults with Incapacity (Scotland) Act 2000 and implied under the Mental Health (Care and Treatment) (Scotland) Act 2003. There are also regulations under the Regulation of Care (Scotland) Act 2001 concerning the use of restraint by care providers. See also Safeguarding Board Act (Northern Ireland) 2011 and Mental Capacity Act (Northern Ireland) 2016.

Restraint exercised without legal authority may be a criminal offence. In these circumstances the individual carrying out the restraint may face prosecution as well as disciplinary action. Any physical act which causes injury, affront or harm to the victim could constitute an assault if there is no lawful justification for its use. The common law recognises that someone may use force or restraint if there is reason to believe another person is about to cause him or her harm. No more than the minimum necessary force can be used. If the person acts in bad faith or uses more force than is reasonably necessary, his or her action is outside the law. No client is to be restrained other than in exceptional circumstances. Staff should use restraint only if this is the only practicable means of securing the welfare of the client or of other clients.

A restrictive practice is only justified in law if there is the presence of a clear and **immediate danger**. The term 'immediate' in this context refers to seconds as opposed to minutes. It does not justify action taken to prevent a possible danger unless incident data clearly shows that a given behaviour or cue quickly results in escalation to a dangerous level, in which case a planned intervention may be justified in the short term, whilst further more positive and proactive strategies are developed (See British Institute of Learning Disabilities Code of Practice).

As well as the presence of a clear and immediate danger staff must also be able to demonstrate that all other available less restrictive options have been tried and failed before the use of a restrictive practice. A useful acronym in this situation is 'TINA' - There Is No Alternative.

The Managing Signs of Stress framework and training offers guidance and a series of non-restrictive and non-aversive techniques to avoid/reduce the use of restrictive practices. There is an expectation that alternatives to a restrictive practice would increase with staff training, experience and knowledge of the individual (RRN Key Strategy 4).

If you can find no alternative to using a restrictive practice then you should use it. (Examples of Non Restrictive Practice see Related Document - SO-0039-002-0617)

- **Duty of Care** – National Autistic Society staff have a duty of care towards the people supported, which requires the organization to take reasonable care to avoid doing something or failing to do something which results in harm to another person. There are situations where some action must be taken and it is a matter of choosing the course of action that would result in the least harm.

- **Best Interest** - The principle of best interest applies. A member of staff must demonstrate that in the presence of a clear and immediate danger they have considered all available alternatives, acted in the best interest of the person in their charge, have considered that not acting could result in greater harm, and does not use unreasonable or excessive force, then the action can be defended in law.

- **Reasonable & Proportionate** - Any force used must be 'reasonable and proportionate', reasonable in that it is the minimum force required to prevent injury and proportionate in that it is not excessive given the seriousness and likely harmful consequences of the person's behaviour. As with all issues to do with caring for, developing and teaching the children, young people and adults we support, decisions need to be made on the best available knowledge at the time.

A useful concept to bear in mind when carrying out any restrictive practice is that of **Social Validity.** During any restrictive practice we should be conscious both of how our intervention may look to others not involved in the interaction and how we would like ourselves, family members or friends to be interacted with in similar circumstances.

5. Restrictive Physical Interventions

All those supported by the National Autistic Society who require any form of behavioural intervention will have a Positive Behaviour Support Plan / Positive Individual Support Plan that provides detailed information relating to all aspects of a person's behaviour and how to support them.

The plan is person centred in its approach setting out details about the individual's behaviours including hypotheses about the functions of a particular behaviour, known as contributory environmental factors, antecedents, triggers, as well as how known behaviours should be recorded when they occur. Whenever possible the plan ought to be produced in collaboration with the autistic individual. The plan described the proactive and reactive

strategies that are to be followed by those supporting the individual to improve the person's quality of life and reduce the risk of harm to themselves or others (RRN Key Strategy 3 & 4).

Part of this reactive plan may include restrictive practices where necessary and deemed in an individuals' best interest.

Where someone has capacity to consent, then they need to agree and sign their plan. Where someone does not have capacity, the plan must be agreed as in their best interest by the relevant people involved in their care (RRN Key Strategy 5).

Restrictive practices can take several forms and may not always involve direct physical force but also chemical restraint, Pro-re-nata (PRN) medication (in the form of sedation), rapid tranquilization, mechanical restraint and environmental restraint, such as the holding of doors or blocking access by use of a person. The use of any PRN will be guided by a specific and individual protocol from the prescribing medical professional. (See Related Document - SO-0039-002-0617 for further details).

Restrictive practices can be categorised as planned or unplanned practices:

5.1 **Planned Restrictive Practice -** pre-arranged interventions based on Risk Management, Training Needs Analysis (TNA) and Restraint Reduction plans, and risk assessments and are clearly recorded in care and positive behaviour support plans. These interventions should be Studio 3 / Positive Behaviour Management sanctioned techniques and staff will be fully trained to carry out these interventions based on the individual needs of the person. They will be agreed as in an individual's best interest and as the least restrictive intervention and used for the least amount of time possible (when the present and immediate danger has passed). The time frame for reporting the use of a Planned Restrictive Practice is within 24 hours of the practice/Intervention taking place.

5.2 **Unplanned Restrictive practices -** an action used in response to unforeseen hazardous events such as a person supported is about to run out in front of a car and There Is No Other Alternative. The time frame for reporting the use of an Unplanned Restrictive Practice is within 24 hours of the practice/Intervention taking place.

5.3 Wherever possible, an unplanned response should still be a Studio 3 / Positive Behaviour Management sanctioned and trained technique. However, in an emergency situation if this was not practicable, but an intervention is still urgently needed to prevent harm to self and/or others, staff must follow the legal principles laid out at the start of this policy and the Managing Signs of Stress training, by providing a reasonable and proportionate response to the situation they are presented with, only when all other options have been explored where and when possible.

5.4 Where unplanned or unintentional incidents of restrictive practices occur, they should always be recorded, opportunity given to debrief, followed by a reflective session to ensure learning and continuous safety improvements (RRN Key Strategy 6).

5.5 If monitoring shows that an unplanned restrictive practice is required on more than one occasion in a 4-week period the individual behaviour support plan/Individual Behaviour Support Plan and risk assessments should be amended to include a

planned restrictive practices, along with proactive measures to reduce the need for such interventions over time (RRN Key Strategy 6).

5.6 **Unacceptable and dangerous intervention -** There are a number of interventions that are either unacceptable, dangerous and often both:

- Prone restraint - Chest on floor / other surface
- Supine restraint - Back on floor / other surface
- Any restraint using the locking of joints
- Any restraint using pain to achieve compliance
- Any restraint that involves forcing the head forward onto the chest area.

The above interventions should be avoided even in emergency situations unless the situation is life threatening. Particular care should be taken with any Physical Practice involving a person with underlying health problems such as swallowing, obesity or heart problems.

When assessing the needs of any individual that requires the use of a restrictive practice as part of their support plan, it is essential that advice is sought from the relevant medical professionals around the use of such practices for the individual when underlying medical conditions are diagnosed and/or apparent.

The following processes should be applied and followed;

- Underlying medical issues identified at assessment stage
- Advice sought as part of any proposed offer of service around the use of Restrictive Practice and the how this may influence any potential regression, relapses or risks to the person
- A risk management plan developed including input and guidance from the relevant professionals around the diagnosis and safe uses of agreed restrictive practices.
- Risk Management plans of this nature should not be carried out without external support from medical services (Consultants etc.).
- Comprehensive post incident checklist and guidance around ensuring any potential effects from the use of such practices have been monitored, recorded and reported to the relevant professionals.
- Where an individual currently accessing our services with underlying medical issues does not have a plan in place, this must be organized internally and the relevant professionals contacted in order to implement the strategies and documentation to support policy expectation.

Medical attention should be sought if a Restrictive Practice has been used to support someone with underlying health issues (RRN Key Strategy 5).

6.Seclusion

Seclusion and segregation are recognised terms in mental health inpatient environments and are defined in the Mental Health Act code of practice. The review seeks to identify to what extent similar practices are used in adult social care environments. The definitions below seek to explain the practice and give examples that might apply in social care

situations. Seclusion normally takes place as a direct response to manage an incident or episode. Segregation is usually an active decision to care for somebody separately.

Seclusion: Seclusion refers to the supervised confinement and isolation of a person, away from other people who use services, in an area from which the person is prevented from leaving, where it is of immediate necessity for the containment of severe behavioural disturbance which is likely to cause harm to others.

The reason for seclusion might be because the person is highly aroused, agitated, overactive, aggressive, is making serious threats or gestures towards others, or is being destructive to their surroundings, when other therapeutic interventions have failed to contain the behaviour.

The Human Rights Act (1998) sets out important principles regarding protection from abuse by state organisations or people working for these institutions (including the National Autistic Society). It is an offence to lock an individual in a room without recourse to the law (even if they are not aware that they are locked in) except in an emergency.

The right to liberty and personal freedom is enshrined in Article 5 of the Human Rights Act (1998) and is protected by the criminal and civil law. For these reasons the use of seclusion outside the Mental Health Act or Mental Health (Care and Treatment) (Scotland) Act 2003 or Mental Capacity Act (Northern Ireland) 2016 should only be considered in exceptional circumstances and should always be proportional to the risk presented by the child or person supported.

In a community setting, any form of environmental restriction imposed on individuals should be legally authorised. Therefore, if it is foreseen that it may be necessary to use a form of environmental restriction such as seclusion beyond dealing with an initial emergency in a community setting, an application should be made for a DoLS under the Mental Capacity Act 2005 or an application for welfare guardianship under the Adults with Incapacity (Scotland) Act 2000 or Mental Capacity Act (Northern Ireland) 2016 should be considered.

Under the Children Act 1989 any practice or measure, such as 'time out' or seclusion, which prevents a child from leaving a room or building of his/her own free will, may be deemed a restriction of liberty. Under this Act, restriction of liberty of children is only permissible in very specific circumstances, for example when the child is placed in secure accommodation approved by the Secretary of State or where a court order is in operation. Advice for staff working in children homes is that seclusion should not be used - if it is used as an unplanned response to prevent harm in an emergency, there should be an immediate review and risk assessment and the production of a plan that considers the use of proactive strategies and less restrictive options.

> *For National Autistic Society Services in **Scotland Only** - refer to best practice from the Mental Welfare Commission for Scotland, Rights and Limits to Freedom and Holding Safely: A Guide for Residential Child Care Practitioners and Managers about Physically Restraining Children and Young People*
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Seclusion can be described obliquely in the following terms, but the principles of its use apply:

- Time out
- Exclusion
- Segregation
- Seclusion
- Safe-space
- Chill out room
- De-escalation room
- Quiet room
- Calming room
- Garden time
- Solitary
- Staff Withdrawal (from Individuals place of residence, behind locked doors)

Seclusion is the **supervised containment** of a person in a room, which may be locked or being held closed, to protect others from significant harm. Its sole aim is to contain behaviour which is likely to cause harm to others. During any period of seclusion, support staff must remain in sight of the individual.

Staff must be able to observe an individual at all times to ensure the person's health and well-being and that their needs are met. This includes access to the toilet, food and drink and activities.

If this is an agreed Restrictive Practice follow the guidance around **Agreed Restrictive Physical Practices.**

If seclusion is used as an unplanned response to a dangerous situation and as a last resort, follow the **Unplanned Restrictive Physical Practice** guidance and section 5.2-5.6 of the policy.

Seclusion should only be used:

- As a last resort
- For the shortest possible time

Seclusion should **never be** used:

- As a punishment or threat
- As part of a behaviour support programme, unless the aim is to introduce a graded restrictive reduction plan where these strategies have been used previously.
- Because of a shortage of staff
- Where there is a risk of suicide or self-harm

6.1 Planned Seclusion

Prior to use, planned seclusion must be discussed with the Director of Adult Services or Managing Director of Education and Nominated Individual as well as ratified with an appropriate legal framework.

Any period of seclusion must be agreed and signed by the Senior Member of shift on duty or the on-call Manager.

Agreed protocols for recording and monitoring planned seclusion must be in place before any period of seclusion.

6.2 Seclusion as an Unplanned Restrictive Practice

If seclusion is used as an unplanned response to an extreme situation, monitoring throughout the period (until the present/immediate danger has passed) must be undertaken in line with the guidance above and as soon as is practicable.

Within 24 hours, the Director of Adult Services or Managing Director of Education and the Nominated Individual must be notified of the incident.

6.3 Segregation

Caring for a person in isolation. The isolation must have been in place for 48 hours or more. It should still be considered segregation even if the person is allowed periods of interaction with staff and or peers.

The reasons for the use of segregation are as follows:

- An individual may be displaying high levels of behaviours of concern/Challenging behaviour (Frequency, Severity, Duration), that is having an impact on others physical or emotional well-being within a shared environment
- An individual's personal hygiene or health is having an impact on others physical or emotional well-being
- To safeguard an individual from potential abuse, bullying from peers, sensory impact, impact to physical or emotional well being

The segregation must be evidence based and in the person's best interest, and should always be agreed on through best interest protocols and procedures.

6.4 Planned Withdrawal

Where there is 'Staff Withdrawal' as part of an individual's Behaviour Support guidelines and/or Restrictive Practice Plan, it needs to be agreed as part of a Multi-disciplinary process and form part of the person's Risk Management and Restraint Reduction plan.

Staff Withdrawal (Seclusion)

If the planned withdrawal includes leaving the person in a room, or in the area where the person resides, with a locked door separating the person from peers or staff members, this is deemed as seclusion and should be:

- agreed on a multi-disciplinary level
- be based on actual risk and present/current risks
- Identified as part of the persons behaviour support and restrictive practice plan
- Have robust monitoring documentation in place
- Be part of Risk Management and Restraint Reduction Plan
- Staff should be fully trained in the use of this intervention, including when, how and logging and reporting systems

Staff Withdrawal (Non-Seclusion)

When Staff withdraw to allow the person to regulate, allow privacy or have been asked to do so by the person. This would be without the use of a locked door acting as a barrier, and the person should have freedom to leave or request staff engagement whenever the person chooses.

- Must be part of the persons proactive support and therapeutic guidelines, led by the person wherever appropriate
- Must have robust monitoring protocols in place to ensure the correct use of the strategy
- Doors must remain unlocked to support the guidance within the strategy and adherence to procedure
- Staff should be fully trained in the use of this intervention, including when, how and logging and reporting systems

7. Principles for the use of restrictive practices

1. When facing behaviour that is potentially dangerous to self and others, staff must act in a measured way, bearing in mind their duty to try to keep the people we support, staff members and themselves safe. Staff should be trained in all techniques relevant to the persons care based on Training Needs Assessment and Risk Management Plan (RRN Key Strategy 3).

2. Additionally, staff have a responsibility to take all reasonable steps –through the inclusion in Positive Individual Behaviour Support Plans, Risk Management and Restraint Reduction plans, and of up-to-date risk assessments related to individuals we support – to safeguard the wider public and property from any potential physical danger from people we support when in the wider community (RRN Key Strategy 3).
3. Where restrictive practices are used they must be proportionate to the risk of harm and the seriousness of that harm.
4. Individuals should, where possible, be involved in any discussion about the use of restrictive practice. Almost all individuals will have some ability to express, verbally or otherwise (e.g. by gesture or by signing), their views about how they wish to be treated, or may have expressed their views in the past. Wherever possible and reasonable, the person's informed, free and full consent to any restraining action should be obtained. The individual's relatives, advocates, welfare attorneys or guardians, circle of support should be involved in discussions about the use of restrictive practice should be agreed as in a person's best interest. In all cases explanation should be given, at a level the person can understand (RRN Key Strategy 5).
5. Under no circumstances should the use of restrictive practices result in pain or pressure on joints.
6. Wherever possible, staff should consult and collaborate with colleagues. The person who is most familiar with the individual and has the best understanding of how to respond to the behaviour should take the lead role. This may cut across line management and seniority.
7. Staff should always explore other possible alternatives. For example, restrictive practices should not be used when a change of staff could have meant it was not necessary.
8. Except in an emergency or where the behavior support guideline indicates to the contrary the only restrictive practices involving bodily contact used should be those approved by Studio III / PBM and only used by staff with appropriate training. It is understood that this may not always be possible during an emergency or where the bespoke behaviour support guideline indicates to the contrary (RRN Key Strategy 3).
9. Where bespoke restrictive practices are required this must be agreed by a multi-disciplinary/transdisciplinary team and all staff who are expected to support an individual must be trained appropriately. This should fall in line with the Restraint Reduction guidance around Training Needs Analysis. Where there is an expectation that an agency or temporary member of staff have achieved the 3-day Managing signs of Stress competency level and be trained and assessed as competent in the bespoke techniques in order to provide the appropriate support needed. (RRN Key Strategy 3)
10. Studio III consultancy service / PBM may approve and train staff in the use of bespoke restrictive practices. In such cases these should be documented within the behavior support plans/guidelines and only used for the individual concerned. Restrictive practices that have not been approved by Studio III / PBM should not be included as part of a planned intervention.
11. All restrictive practices should be carried out for the least time necessary. Where appropriate the environment should be made safe or the person or others (depending on which is the least restrictive) supported to move to a safer environment to reduce the intervention time.
12. Staff should refer to positive individual behaviour support guidelines which detail all the strategies and interventions used, including restrictive practices, to help the child, young

person or adult manage their behaviour - see Policy on Behaviour Support in Schools and Adult Services (SO-0029) (RRN Key Strategy 4).

13. Particular care needs to be taken over the use of restrictive practices when a person we support is engaging in self-injurious behaviour (SIB) or deliberate self-harming. A full risk assessment needs to inform the strategy to support individuals who engage in SIB or self-harm. Only agreed, trained restrictive practices can be used, only as a last resort and only when it has been decided that more harm will result from not using them.
14. After any restrictive practice has been used an independent person who has not been involved should check the child, young person or adult for any injuries or any signs of potential injuries.

8. Debriefing (RRN Key Strategy 6)

- For reference, debriefing in the context of this document, is giving the opportunity to an individual after an incident has occurred to discuss the emotional impact the incident has had on them. It allows the person to speak freely and openly about how the incident has made them feel and be supported to move on from the incident.

- The debriefing session should always remain confidential and not be used to influence changes to behaviour support guidelines or used as an opportunity to analyse or reflect on the individual's practice. Reflective Supervision or Incident Analysis are two other forms of post incident processes, which offer the opportunity to reflect, analyse and where possible, improve on practice, and should only take place after the debrief proper has been offered/completed.

- The Debrief is optional and the individual member of staff, or person we support has the right to refuse the opportunity to be debriefed after an incident. This should be logged on the CARESYS incident form / X in the appropriate section.

- In Schools when a 'Debrief session has taken place, it is logged as part of the incident recording on CPOMS.

- Debriefing must be given to the child, young person or adult who has been restrained in line with the guidance in their positive behavior support guidelines.

- Debrief should be offered or sought out as soon after the incident as is possible

- Narrative around the content of the debriefing session should not be taken, however, the offer of and acceptance/refusal of the session should be logged on the CARESYS form, or CPOMS in Schools as part of the Incident recording.

9. Training (RRN Key Strategy 1-5)

All training which includes the use of Physical Interventions and Restrictive Practices should be assessed by Service and Individual needs. The process will be managed through the use of a Tiered Service/School approach and Individual Risk Management Planning and Training needs assessments. (RRN Key Strategy 3, 4 & 5).

Any agreed plan around the training of staff in the use of Restrictive Practices, should include a completed Restraint Reduction Plan as part of the overall plan, and should be monitored in line with our internal monitoring and reviewing processes to ensure the justified and necessary use of the restriction, and promote the reduction where proactive management plans are in place and working for the individual (RRN Key Strategy 6).

Tiered Framework

Tier One

Tier 1 focuses on services and schools (classes) where we see no, to minimal episodes of behaviours that challenge from the people we support, and are considered to be low risk.

These services include:

- Outreach
- Supported living Services
- University/College Support
- Social Enterprises
- Inclusive of Admin Staff and Volunteers

This guidance must be followed:

1. All staff working in Tier 1 Services or Schools are to be trained in Managing Signs of Stress Day 1 Theory, as a minimum requirement. Staff will be expected to demonstrate the retention and understanding of the theory element of the training by completing a 20 question Multiple choice questionnaire post training.
2. An Additional 6 hours training in supporting Individuals positively, proactively and understanding individual's needs (PBS, SPELL and Autism Awareness) as part of their induction into our organisation, this a minimum requirement (RRN Key Strategy 1).
3. All Staff are expected to attend annual theory refreshers.
4. Training can be remote or class room based.

Tier Two

Tier 2 focuses on services and schools (classes) where we see minimal, to medium levels of behavioural presentation (Higher frequency, higher level of severity), and would require staff members to be well versed in the use of breakaway techniques, and understand the importance of being aware of yourself, your environment and the potential risks of supporting people that access these services and schools.

These services include:

- Some supported living services (Lone working)
- Day Service Resources
- Schools and Classes
- Some Residential Services

This guidance must be followed:

1. Where there is a need for staff to be trained in any form of Physical Intervention, or the use of Restrictive Practice, a Risk Management, Training Needs Analysis and Restraint Reduction Plan, if required, should be completed. A Training Request form should then be sent out by Service Manager or PBS Team.
2. Physical Skills Training should be based on service and individual need.
3. Staff will need to attend a minimum of Managing Signs of Stress Day 1 Theory and Day 2 Physical Skills Person/Service based Training.
4. An additional 6 hours training in supporting Individuals positively, proactively and understanding individual's needs (PBS, SPELL and Autism Awareness) as part of their induction into our organisation, this a minimum requirement (RRN Key Strategy 1).
5. If there is a need for Restrictive Practice - training on the 3rd day will need to take place based on the Training Needs Analysis.
6. Annual Refreshers will need to be attended by all Tier 2 staff in the Theory Element and any needs assessed physical skills.
7. Theory training (remote) can be attended separately to the physical skills elements of the course (must be class room based).

Tier Three

Tier 3 focuses on services and schools (classes) where we see high levels of behaviours that challenge and high levels in the use of restrictive practices and unplanned restrictive practices (High Frequency, High Severity, High risk, Increased Duration). Such environments and individuals require staff members to be trained and highly skilled in the use of the physical skills taught in the 3 Day Managing Signs of Stress training framework (days 2 and 3), and again, understanding the importance of being aware of yourself, your environment and the potential risks of supporting people that access these services and schools.

These services include:

- Schools
- Residential Services
- Day Service Resources
- Some single occupancy Supported Living Services
- Bank Staff and Regular use Agency Staff should be trained to Tier 3 level

This guidance must be followed:

1. Where there is a need for staff to be trained in any form of Physical Intervention, or the use of Restrictive Practice, a Risk Management Training Needs Analysis and Restraint Reduction Plan, if required, should be completed. A Training Request form should then be sent out by Service Manager or PBS Team.

2. Physical Skills Training should be based on service and individual need.
3. Staff will need to attend a minimum of Managing Signs of Stress Day 1 Theory and Day 2 Physical Skills Person/Service based Training and Day 3 the use of Restrictive Practices, again, all training must be needs assessed.
4. An additional 6 hours training in supporting Individuals positively, proactively and understanding individual's needs (PBS, SPELL and Autism Awareness) as part of their induction into our organisation, this a minimum requirement (RRN Key Strategy 1).
5. If there is a need for Restrictive Practice - training on the 3rd day will need to take place based on the Training Needs Analysis.
6. Annual Refreshers will need to be attended by all Tier 3 staff in the Theory Element and any needs assessed physical skills.
7. Theory training (remote) can be attended separately to the physical skills elements of the course (must be class room based).

Tier Four

Tier 4 - service/school trained staff members will hold specific/bespoke methods around the use of restraint that fall outside of the generic Managing Signs of Stress training.

These techniques will be agreed at a multidisciplinary level and sanctioned by Studio 3 training LTD.

1. Where there is a need for staff to be trained in any form of Physical Intervention, or the use of Restrictive Practice, a Risk Management Training Needs Analysis and Restraint Reduction Plan, if required, should be completed. A Training Request form should then be sent out by Service Manager or PBS Team.
2. Physical Skills Training should be based on service and individual need.
3. Staff will need to attend a minimum of Managing Signs of Stress Day 1 Theory and Day 2 Physical Skills Person/Service based Training and Day 3 the use of Restrictive Practices, again all training must be needs assessed, along with an additional work shop in the specific use of a Tier 4 strategy.
4. An additional 6 hours training in supporting Individuals positively, proactively and understanding individual's needs (PBS, SPELL and Autism Awareness) as part of their induction into our organisation, this a minimum requirement (RRN Key Strategy 1).
5. If there is a need for Restrictive Practice - training on the 3rd day will need to take place based on the Training Needs Analysis.
6. Annual Refreshers will need to be attended by all Tier 4 staff in the Theory Element and any needs assessed physical skills.
7. Any additional Tier 4 sanctioned techniques will be monitored and trained in line with the specific needs of the individual, the team and the Restraint Reduction Program.
8. Theory training (remote) can be attended separately to the physical skills elements of the course (must be class room based).

10. Recording, reporting and monitoring (RRN Key Strategy 6)

1. For any incident involving the use of restrictive practice, a behavioural incident / CPOMS record must be completed by the end of the shift and where appropriate, formally reported to outside agencies (CQC, Ofsted, Care Inspectorate, CIW, RQIA) within 24 hours in writing in accordance with the protocol in the school or adult service. Information to be recorded is listed in Related Document SO-0039-001-0617.

2. Use of environmental change to restrict movement, use of medication/PRN to manage challenging behaviour or reduce risk of harm and use of mechanical restraint all require recording on a restrictive practice form – See Related Document SO-0039-003-0617 and SO-0039-04-0617.

3. The above is to be written onto a Restrictive Physical Intervention (RPI) form / CPOMS record that is kept by the service, and will be monitored and signed off by the senior leadership team.

4. An accident record should be completed if there is any injury.

5. The completed record, with the incident form should be signed off by the appropriate senior staff member in accordance with the school or service's protocol.

6. Positive Behaviour Support plans must give clear strategies to reduce dependency on Restrictive Practice over time.

7. The use of all restrictive practice programmes must be reviewed by the support team following any incident that results in use of a restrictive practice. All plans must be reviewed formally at least 6 monthly.

8. After any use of Restrictive Practice, the positive behaviour support plan and risk assessments should be reviewed and updated if/as necessary.

11. Responsibilities

Trustees

- Trustees review of policy on the use of Restrictive Practices.
- Trustees will monitor the reduction in use of Restrictive Practices on a quarterly basis.

Director - Adult Services / Education

- Monitoring of implementation of this policy
- Monitor the use of Restrictive Practices on a regular basis
- Ensuring the allocation of internal and external resources (including clinical and counselling) to address the needs of individuals we support and staff with regard to the implications of serious challenging behaviour

Principals, Area Managers and National Autistic Society Service Managers

- Enforcing the implementation of this policy in their school or adult service
- Maintaining a comprehensive recording and reporting process relating to the use of restrictive practices
- Ensuring relevant staff undergo training in the use of restrictive practice, with regular refreshers; currently provided by Studio III / PBM
- Supporting care teams in developing risk assessments and behaviour support and care plans with regard to restrictive practices – with particular reference to calling for external or internal expert opinion as required.
- Ensuring plans are shared with parents/advocates, purchasers and other interested agencies, and where appropriate with the child or adult concerned, recognising the importance of consent in terms of the fundamental issues of respect and dignity.
- Regular monitoring of such plans.

All Staff

- Working always in the best interests of the child or adult.
- Taking part in training provided in the use of restrictive practices and applying the principles and strategies taught.
- Satisfying themselves that they are clear on what they may and may not do in terms of restrictive practices, seeking clarification as necessary.
- Using Support & Supervision sessions to confirm their understanding of this policy and to seek further explanation or personal development as necessary.
- Following the recording and reporting procedures.
- Contributing to the development of behaviour support or care plans, and good practice.

12. Complaints

Adults, parents, guardians, carers or children and young people have the right to offer comments and refer to the local complaints procedure (or Complaints Resolution (services) Policy QS-0009/ Complaints Resolution in Schools QS-0010) in the case of any disagreement in the use of restrictive practices.

Alternatively contact can be made with the appropriate external regulator: Care Quality Commission (England) / Care Inspectorate Wales / the Care Inspectorate, Scotland / Regulation and Quality Improvement Agency (Northern Ireland) / Ofsted – details can be found on the internet.

13. Whistleblowing

Employees of the National Autistic Society have a duty to voice any concerns over care practice. Please refer to the Policy on Whistleblowing (HR-0002) for further information.

References

KCSiE 2020

Whistleblowing Policy – HR-0002

Behaviour Support in Schools & Adult Services SO-0029

Complaint Resolution (Services) Policy QS-0009

Adult Support and Protection (Scotland) Act 2007

Positive and Proactive Care: reducing the need for restrictive interventions (2014)

Code of Practice for the use and reduction of restrictive practices. 3rd edition (2010) BILD

Care Standards Act 2000

Carers Guide to Physical Interventions and the Law (2005) Christina Lyon and Alexandra Pimor, BILD, ISBN 1-904082-815

Children (Scotland) Act 1995

Holding Safely: A Guide for Residential Child Care Practitioners and Managers about Physically Restraining Children and Young People. *The Scottish Institute for Residential Child Care 2013*

Children's Act 1989

Children's Homes Regulations (2001) – amendment (2011)

Use of Reasonable Force - Department for Education - www.education.gov.uk

Guidance on the Use of Restrictive practices for Pupils with Severe Behavioural Difficulties - *Department* for Education – www.education.gov.uk

Easy Guide to Physical Interventions for people with Learning Disabilities, their Carers and Supporters (2002) BILD, ISBN 1-902519- 973

Education and Inspection Act 2006

Welsh Assembly - Framework for Restrictive practice Policy and Practice - March 2005

Good practice in Physical Interventions (2006) Ed Sharon Paley and John Brook, BILD, ISBN 1-904082-742

Human Rights Act 1998

Mental Capacity Act 2005.

Mental Health act 1983 Code of Practice (2015 Revision) The Stationery Office London – www.tsoshop.co.uk

Mental Capacity Act 2005, s20

Adults with Incapacity (Scotland) Act 2000

Mental Health Care and Treatment (Scotland) Act 2003

The Children (Northern Ireland) Order 1995

Safeguarding Board Act (Northern Ireland) 2011

Mental Capacity Act (Northern Ireland) 2016

Mental Welfare Commission for Scotland, Rights and Limits to Freedom - www.mwcscot.org.ukPositive and Proactive care: reducing the need for restrictive interventions (April 2014) Department of Health

Rights, Risks and Limits to Freedom – Mental Welfare Commission

Murphy, G. & Wilson, B. (1985) *Self-injurious Behaviour*. British Institute of Learning Disabilities, Kidderminster. – www.BILD.org.uk

Education and Inspections Act 2006 *(Part 7, Discipline, Behaviour and Exclusion)*. www.legislation.gov.uk

Regulation of Care (Scotland) Act 2001. www.scotland.gov.uk/publications

The Care Act 2014

Related Documents

SO-0039-001-0617	Information to be recorded for each use of a Restrictive practices
SO-0039-002-0617	Non-Restrictive & Restrictive Intervention Practice
SO-0039-003-0617	Restrictive Practice Form
SO-0039-004-0617	How to complete Restrictive Practice Form
SO-0039-005-0617	Procedure for Admission to a School or Service where an individual is dependent on seclusion or restraint to manage his or her behaviour
SO-0039-006-0919	Unplanned Restrictive Response Reporting
SO-0039-007-1120	Managing Signs of Stress Framework
SO-0039-008-0221	Incident Analysis Form
SO-0039-009-0918	Studio 3 Verification Sheet
SO-0039-010-1120	Protocol for Unplanned Restrictive Practices
SO-0039-011-1120	Training Request / Referral Form

SO-0039-012-1120	Restrictive Practice Management and Restraint Reduction Plan